UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

CARMEN CORREA on behalf of herself and all others similarly situated, PLAINTIFF, v. **COURTNEY E. HAWKINS,** in her official capacity as Director of the Rhode Island Department of Human Services, DEFENDANT.	Case Number: 19-cv-00656-JJM-PAS

STIPULATION OF SETTLEMENT

WHEREAS, this action was commenced by Plaintiff pursuant to 42 U.S.C. § 1983 under the Due Process Clause of the Fourteenth Amendment of the United States Constitution and federal statutes and regulations;

WHEREAS, Defendant denies any and all claims of wrongdoing asserted in connection with Plaintiff's complaint;

WHEREAS, no finding of liability has been made;

WHEREAS, the parties wish to avoid the expense and disruption of litigation on the issues presented in this litigation and are prepared to settle their differences without admitting any fault or liability;

NOW, THEREFORE, UPON THE STIPULATION AND AGREEMENT OF THE PARTIES, through their undersigned attorneys for the respective parties herein, that this action is settled, subject to the approval of this Honorable Court pursuant to the Federal Rules of Civil Procedure, on the following terms and conditions:

I. TERMS AND DEFINITIONS

1. Defendant Courtney Hawkins, in her official capacity as Director of the Department of Human Services, is responsible for the administration in Rhode Island of the federal Supplemental Nutrition Assistance Program ("SNAP"), pursuant to the Food and Nutrition Act of 2008. Pub. L. No. 110-246, §§ 4001-02, 122 Stat. 1651, 1853-1860.

2. Rhode Island is required to collect amounts incorrectly provided to SNAP recipients under certain circumstances. These amounts of overpayment are called "overissuance" of SNAP benefits. The recoupment process is governed by federal constitutional, statutory and regulatory requirements.

3. By federal regulation, there are three types of claims for which collection is required: (1) Intentional Program Violation (IPV) ["IPV"], (2) Inadvertent Household error ["IHE"], and (3) Agency error ["AE"]. 7 C.F.R. § 273.18(b).

4. This Agreement applies only to Overissuance claims for IHE and AE.

5. This Agreement applies only to Overissuance claims asserted since on or after May 1, 2019.

II. DEFENDANT'S OBLIGATIONS

6. Defendant Hawkins certifies that she has satisfied the requirements of Paragraph 2 of the Temporary Restraining Order, as extended by the parties to February 7, 2020, as evidenced by:

a. sending each individual issued a SNAP Overissuance Letter due to Agency Error or Household Error during the period commencing May 1, 2019 through December 18, 2019, a letter advising the individual that the previous Overissuance Letter has been withdrawn ("notice of withdrawal") and that the reduction of any SNAP benefits pursuant to such notice has been

terminated. The notice of withdrawal requirement does not apply to: individuals (i) who, prior to the date of the Temporary Restraining Order, have entered into an individualized repayment plan by agreement; (ii) whose overissuance case has been closed or terminated; or (iii) whose claim is in suspended status.

b. Defendant certifies that the notice of withdrawal was provided in English, Spanish, or Portuguese and was mailed on February 7, 2020.

c. A redacted copy of the notice of withdrawal was provided to Plaintiff's Counsel on February 7, 2020.

d. Plaintiff's Counsel agree that the notice of withdrawal is acceptable and, subject to Defendant's compliance with subparagraph (e) below, that the Defendant has timely satisfied the requirements of Paragraph 2 of the Temporary Restraining Order.

e. Within 60 days of the date of execution of this Stipulation or at an earlier time at the Defendant's discretion:

(1) the Defendant will provide Plaintiff's Counsel with a list of individuals who were sent an Overissuance Letter during the period commencing May 1, 2019 through December 18, 2019 on the basis of IHE or AE , which list shall include (i) the date that the notice of withdrawal was sent to said individual or (ii) the reason that a notice of withdrawal was not required. This list shall hereinafter be referred to as the "Collection List" and shall be updated with additional information in the form and at the times set forth hereinafter. Acknowledging that the individuals on the Collection List, other than Plaintiff Correa, are entitled to confidentiality pursuant to 7 U.S.C. § 2020(e)(8), 7 C.F.R. § 272.1(c), and R.I. Gen. Laws § 40-6-12, only the individual recipient's initials (other than Plaintiff Correa) will be documented on the list.

(2) the Defendant will certify that no Overissuance Letters were issued on the basis of IHE or AE at any time from December 18, 2019 to the date of entry of the within Stipulation, and if the Defendant is not able to so certify, Defendant shall identify each such individual on the Collection List and include separately as to each such individual (i) the date that an Overissuance Letter was issued; (ii) the date that the notice of withdrawal was sent to said individual; or (iii) the reason that a notice of withdrawal was not required.

7. Defendant agrees that the Department of Human Services ("DHS") shall not initiate, process, or continue to process monthly SNAP benefit reductions for those individuals, including the Plaintiff, who have been issued SNAP Overissuance Letters during the period commencing May 1, 2019 to December 18, 2019 unless new SNAP Overissuance Letter includes the information set forth herein, whether or not the time to claim an administrative appeal set forth in the SNAP Overissuance Letter has expired. This requirement does not apply to: individuals (i) who, prior to the date of the Temporary Restraining Order, have entered into an individualized repayment plan by agreement; (ii) whose overissuance case has been closed or terminated; or (iii) whose claim is in suspended status.

8. Defendant agrees that DHS shall not schedule or conduct administrative hearings based upon appeals for those individuals who have filed an appeal after having been issued SNAP Overissuance Letters during the period commencing May 1, 2019 through December 18, 2019 unless said SNAP Overissuance Letter is reissued and includes the agreed upon information set forth herein.

9. Defendant agrees that SNAP Overissuance Letters issued hereinafter must include at a minimum, recognizing that the text box referenced in subsection (e) and as the text box may appear in Exhibits A1 and A2 are at DHS's discretion:

a. All non-individual specific information provided in the agreed upon SNAP Overissuance letters as provided for in Exhibit A1 (current recipient) and Exhibit A2 (no longer a recipient) as well as information concerning the relevant code, description of overissuance reasons, and information concerning the calculation of the overissuance by month and year (although if the reason for the change(s) is consistent and spans several months, the months may be listed in the aggregate), as provided for in the exemplars attached hereto as Exhibits B-1 through B-4. These exemplars contain sufficient information to satisfy this requirement, and the information may be provided in the same or materially similar format with the same or materially similar content;

b. The relevant code and full description, as provided in Exhibit C. Plaintiff's Counsel have reviewed and are in agreement with the codes and descriptions of overissuance reason(s) provided in Exhibit C;

c. For items with codes AE22 and IHE22, the notice will include the type of assets/resources that were not previously included in determining the amount of SNAP benefits;

d. For an item with code 100, the notice will provide sufficient detail so the recipient will have information of the reason for the overissuance;

e. The notice may also include a text box in which DHS at its discretion may manually provide additional information or details concerning the facts or circumstances underlying the agency's determination;

f. If multiple reasons are included in the same notice, the notice shall identify the change in income or deductions attributable to each reason and each applicable month, provided, however, that if the reason for the change(s) is consistent and spans

several months, the months may be listed in the aggregate. If the reasons for the changes differ on monthly detail, DHS will provide additional detail attributable to each reason.

10. The parties understand and agree that the notices as detailed in Paragraph 9 must be submitted to, reviewed and approved by the USDA Food and Nutrition Service ("FNS"). While the parties understand and anticipate that the date of deployment of notices is estimated as September 18, 2020, deployment is conditioned upon FNS approval and if additional time is needed to obtain such approval, then the parties shall extend the time by written agreement or if no agreement can be reached, either jointly or individually, will notify and seek a conference with the District Court.

11. If DHS does not reissue SNAP Overissuance Notices containing the agreed upon information within 45 days of the deployment of the letters in RI Bridges and the recipient had SNAP benefit reductions processed before the issuance of the Temporary Restraining Order, DHS will restore said SNAP benefit reductions, retroactively to each individual described in paragraph 6 of this Stipulation by 90 days of the deployment of the letters in RI Bridges. The Defendant shall update the Collection List no less than once every 90 days after commencement of issuance of replacement Overissuance Notices to reflect, as to each individual identified therein, (i) the issuance of a replacement Overissuance Notice; (ii) the restoration of SNAP benefit reductions; or (iii) a description of other reason.

III. PROGRESS REPORTING

12. Notice of first deployment of new notices:

a. Advance notice: DHS will notify Plaintiff's Counsel no later than ten (10) days in advance of the intended or anticipated date of first deployment of new notices; and

b. Confirmation: DHS will notify Plaintiff's Counsel no later than ten (10) days after the date the new overissuance notices were deployed in DHS's integrated eligibility system.

c. District Court Notification: DHS will notify the District Court of the date the new overissuance notices were deployed in DHS's integrated eligibility system.

13 Within thirty (30) days following the end of the Federal Fiscal Year quarter ("FFY) in which the new notices are deployed in DHS's integrated eligibility system, DHS will send to Plaintiff's Counsel either a certification by counsel or a declaration by a DHS representative detailing:

a. The date the new overissuance notices were deployed in DHS's integrated eligibility system;

b. The number of new claims established for AE and IHE, including total collections on those claims in the last FFY Quarter;

c. A copy of FNS-209 report for the last available FFY Quarter;

d. Copies of twenty-five percent (25%) of the total overissuance notices for AE and IHE claims sent out during the FFY Quarter. Personally identifying information will be redacted so as to comply with Federal and State law and regulations; and

e. The number of repayments agreements received in the FFY quarter for AE or IHE claims.

14. Thereafter, within thirty (30) days after the close of the three (3) subsequent FFY quarters during which the District Court has jurisdiction over this case, Defendant Hawkins shall provide Plaintiff's counsel:

a. The number of new claims established for AE and IHE, including total collections on those claims in the last FFY Quarter;

b. A copy of FNS-209 report for the last available FFY Quarter;

c. Copies of twenty-five percent (25%) of the total overissuance notices for AE and IHE claims sent out during the last FFY Quarter. Personally identifying information will be redacted so as to comply with Federal and State law and regulations; and

d. The number of repayments agreements received for the last FFY quarter for AE or IHE claims.

IV. GENERAL PROVISIONS

15. No provision herein shall infringe upon any individual recipient's right to contest, compromise or appeal an Overissuance Notice pursuant to the federal regulations or Rhode Island Administrative Procedures Act.

16. Except to the extent set forth herein, the terms and conditions of this Stipulation shall become effective upon the date of entry of the Stipulation of Settlement by the Court.

17. This Stipulation is final and binding upon the parties, their successors, and assigns.

18. The Parties recognize and acknowledge that the only consideration for signing this Stipulation are the terms stated herein and no other promise, agreement, or representation of any kind has been made to any party by any person or entity whatsoever to cause any party to sign this Stipulation of Settlement.

19. This Stipulation of Settlement constitutes a compromise settlement of disputed and contested matters between the Parties. It shall not be construed as an admission of any sort by any of the Parties, nor shall it be used as evidence in a proceeding of any kind, except as necessary to administer and/or enforce the terms of this Stipulation of Settlement.

20. This Stipulation of Settlement constitutes an integrated Stipulation of Settlement, containing the entire understanding of the Parties with respect to the matters addressed herein and,

except as set forth in this Stipulation of Settlement, no representations, warranties, or promises, oral or written, have been made or relied on by the Parties. This Stipulation of Settlement shall prevail over any prior communications between the Parties or their representatives relative to matters addressed herein. This Stipulation of Settlement may not be changed unless the change is in writing and signed by the Parties or by order of the Court.

21. The Parties warrant and represent that they have read and understand the foregoing provisions of this Stipulation and that they and their respective signatories are fully authorized and competent to execute this Stipulation on their behalf.

VI. ENFORCEMENT

22. Plaintiff may move for enforcement of this Stipulation, including the remedy of extension of the Court's jurisdiction, based on a showing of systemic non-compliance by Defendant with the terms of this Stipulation. Prior to bringing any such motion, Plaintiff will be required to provide written notice to Defendant detailing any claim of systemic non-compliance. Within fifteen (15) business days thereafter, or at such time as the parties mutually agree upon, the parties shall confer by telephone or in-person in a good faith effort to resolve the dispute. If the parties are unable to resolve the dispute, Plaintiff may file a motion for enforcement with the Court.

23. In the event that Plaintiff moves for enforcement of this Stipulation, including the remedy of extension of the Court's jurisdiction, Defendant shall not object to the standing or mootness of the Plaintiff to make that motion or to seek relief generally applicable to all persons similarly situated, nor shall Defendant interpose facts concerning the standing or mootness of the Plaintiff to bring such motion, nor shall Defendant object to the intervention or adding of such other additional individual Plaintiff SNAP recipients who seek to enforce the Stipulation.

VII. JURISDICTION

24. This Stipulation shall take effect upon execution by the parties and entry by the Court.

25. The Court shall retain jurisdiction for a period of (12) months from the date of first deployment of the notices or entry of the Stipulation by the Court, whichever shall last occur, unless otherwise extended by the Court after adjudication and a finding of the Defendant in systemic non-compliance. Absent such extension, the Court's jurisdiction herein shall automatically terminate unless upon a motion by the Plaintiff alleging systemic noncompliance. Defendant reserves the right to object to the motion.

26. This Stipulation and all obligations herein shall terminate and this Stipulation shall have no force and effect retrospectively or prospectively five (5) years from the effective date of this Stipulation or first deployment of the notices, whichever date shall last occur. This is self-executing and does not require any affirmative action by the Defendant before the Court.

27. Given that negotiations and time frames set forth and agreed to by the parties has occurred during the unprecedented times of the COVID-19 pandemic and the resources of both the Federal and State Governments are addressing COVID-19 related matters, the dates set forth in Paragraphs 11, 12, 13, and 14 may be affected and result in the need for adjustment. If the dates set forth in Paragraphs 11, 12, 13, and 14 require readjustment and the parties cannot mutually agree to replacement dates, either party, separately or jointly, may move for a conference with the District Court to assist with resolution.

VIII. ATTORNEYS' FEES AND COSTS

28. The parties agree to the payment of attorneys' fees and costs in the amount of $58,000 in attorneys' fees and $713.25 in costs representing a compromise of attorneys' fees and

costs and Plaintiff, counsel, their firm, business, and/or the ACLU that they are employed by or affiliated with, waive their right to seek and be awarded attorney's fees and costs under 42 U.S.C. § 1988 or any other statute, regulation or common law for legal services and expenses incurred up to and including the date of entry of the within Stipulation and without prejudice to a further application for attorneys' fees and costs for services and expenses incurred after the date of entry of the within Stipulation in connection with seeking or obtaining compliance with its terms through Court proceedings, but excluding routine monitoring to confirm Defendant's compliance with the terms and time frames set forth herein. Said payment shall be made by the Defendant within forty-five (45) days of entry of this Stipulation of Settlement by the District Court as follows:

To Ellen Saideman: $34,574.00 in fees and $713.25 in costs; and

To Lynette Labinger: $23,426.00 in fees.

29. The sharing of the tribunal-approved award with the American Civil Liberties Union Foundation of Rhode Island is consistent with this Court's decision in *RI Training School v. Martinez*, 465 F. Supp. 2d 131 (D.R.I. 2006) and Rhode Island R.P.C. 5.4(a)(4).

30. The parties agree that Defendant's collection of overissued SNAP benefits is governed by federal law and regulations and that Defendant must at all times comply with federal and state law. Accordingly, this Stipulation and Order of Settlement is subject to any applicable changes in federal law or regulations. Nothing in this agreement prohibits the Defendant from seeking a modification by consent of the parties of by Order of the Court, upon which Defendant shall bear the burden of proof, on the basis that there has been a change in federal or state law or federal regulation

Dated: May 8, 2020

Plaintiff, by her attorneys,

/s/ Ellen Saideman
Ellen Saideman, Esq. (Bar No. 6532)
Law Office of Ellen Saideman
7 Henry Drive
Barrington, RI 02806
Telephone: 401.258.7276
Facsimile: 401.709.0213
Email: esaideman@yahoo.com

/s/ Lynette Labinger
Lynette Labinger, Esq., (Bar No. 1645)
128 Dorrance Street, Box 710
Providence, RI 02903
Telephone: 401.465.9565
LL@labingerlaw.com
Cooperating counsel
AMERICAN CIVIL LIBERTIES UNION
FOUNDATION OF RHODE ISLAND

Defendant, by her attorneys,

/s/ Brenda D. Baum
Brenda D. Baum, Bar No. 5184
Assistant Attorney General
150 South Main St. Providence, RI 02903
Tel: (401) 274-4400 (Ext. 2294)
Fax: (401) 222-2995
bbaum@riag.ri.gov

/s/ Sean Lyness
Sean Lyness, (#9481)
Special Assistant Attorney General
R.I. Department of Attorney General
150 South Main Street
Providence, RI 02903
Tel. (401) 274-4400 (Ext. 2481)
Fax. (401) 222-3016
slyness@riag.ri.gov

ENTER:

UNITED STATES CHIEF JUDGE

Dated: May 11, 2020

STATE OF RHODE ISLAND
P.O BOX 8709P.O BOX
8709
CRANSTON, RI 02920-8787

Date: 04/03/2020
Case Number: Mockup1 (change in HH size)

HOH's Name
<Address Line 1>
<Address Line 2>
<City, State Zip code>

How to Contact Us
Go Online: www.healthyrhode.ri.gov

For questions about affordable health coverage or human services programs, call Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347)

DEMAND LETTER FOR SNAP OVERISSUANCE

Dear <Head of Household's Name>,

For a detailed calculation of the overpayment amount, please see attached overissuance worksheet.

Please sign the enclosed repayment agreement and return it to this office within thirty (30) days or by 05/04/2020. If you fail to make an agreement and fail to make a payment, further appropriate action will be taken to recover the overpayment.

Should your household's circumstances change, you have the right to request a renegotiation of this repayment agreement. DHS may reduce any part of the claim if the agency believes that the household is not able to repay the claim. You may make this request by contacting the DHS Claims, Collections, and Recoveries Unit at (401) 415-8400.

If you wish to obtain a lawyer, representatives from Rhode Island Legal Services, Inc. may be available to represent you, without charge. Their telephone number is (401) 274-2652 or 1-800-662-5034. Make checks or money orders payable to: Rhode Island Department of Human Services. Please include your claim number on your check/money order.

OPTIONS FOR REPAYMENT

You must repay us for the over issued benefits you received. You may repay us by making a cash repayment agreement or Electronic Benefit Transfer (EBT) Card Payment. If you do not choose a repayment option and you are active on SNAP benefits, your monthly will be automatically reduced. Additional information about selecting your repayment method appears later on this notice.

You must make arrangements to repay us and return the agreement portion of this form by 05/04/2020 to the DHS Claims, Collections and Recoveries Unit at 195 Buttonwoods Ave, Warwick, RI, 02886.

We intend to collect from all adults who were in the household when the over issuance occurred, whether they stay in the same household or move to a different household.

PENALTIES FOR NONPAYMENT

If you fail to make an agreement or you make an agreement and fail to make a payment, further appropriate action will be taken to recover the overpayment. If you are currently receiving SNAP benefits, your SNAP allotment may be reduced as early as the month following the date of this letter.

Failure to enter into a Voluntary Repayment Agreement or failure to pay after making an agreement will result in this claim being submitted to the Treasury Offset Program (TOP). TOP is a federal program for collection of debts that includes but is not limited to IRS Tax Refund Intercepts, Federal Salary Offsets, and Social Security Administration (SSA) recoupments. Fees may also be added to the debt for TOP offsets. TOP can be avoided by repaying the debt in full or agreeing to an acceptable repayment agreement on the following pages. If you have filed for bankruptcy, your claim will not be referred to TOP while there is an automatic stay in place.

Federal regulations allow the states to use various collection methods to collect this claim, including the use of private collection agencies, state tax refund and lottery offsets, wage garnishments, property liens and small claims court.

If a claim becomes delinquent, the household may be subject to additional processing charges. **A default of the repayment agreement will result in the entire debt becoming immediately due and payable.**

YOUR RIGHTS

You have a right to discuss this agency determination of overpayment, or the amount of overpayment further with DHS and to request an adjustment conference with the supervisor.

You also have a right to inspect and copy our records relating to this claim.

If you disagree with this determination, you have a right to a hearing. However, you must appeal this action within 90 days of the date of this notice, which is [redacted] (See enclosed Appeal Form). If you have already received a Fair Hearing on this claim, you will not be able to appeal again. Please see your original hearing decision.

If you have any questions regarding this notice, call the Claims, Collections and Recoveries Unit at (401) 415-8400.

OVERISSUANCE SUMMARY

[redacted]

[redacted]

[redacted]

[redacted]								
[redacted]								
[redacted]								
[redacted]								
[redacted]								
[redacted]								

[redacted]

[redacted]

[redacted]

STATE OF RHODE ISLAND
P.O BOX 8709P.O BOX
8709
CRANSTON, RI 02920-8787

Date: 04/03/2020
Case Number: Mockup1 (change in HH size)

HOH's Name
<Address Line 1>
<Address Line 2>
<City, State Zip code>

How to Contact Us
Go Online: www.healthyrhode.ri.gov

For questions about affordable health coverage or human services programs, call Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347)

REPAYMENT AGREEMENT

FOR HOUSEHOLDS RECEIVING SNAP BENEFITS AT THIS TIME

If you are receiving SNAP benefits at this time, you may repay the entire amount of the claim in cash, funds from an EBT Benefit account, or check or money order all at once by **05/04/2020**. If you do not pay the entire amount due by this date, your benefits will be reduced by 10% of your household's monthly allotment, which is $1 or $10.00 per month, whichever is greater (see allotment reduction option below for more information).

Please choose a repayment option below, sign, date and return this form by **05/04/2020.**

☐ PAYMENT IN FULL OPTION

I agree to repay the over issuance amount of $_____ with this repayment option.

Make checks or money orders payable to: Rhode Island Department of Human Services. Please include your social security number on your check/money order.

Mail form and payment to:
DHS Claims, Collections and Recoveries Unit
195 Buttonwoods Ave
Warwick, RI, 02886

Enclosed Amount: $_____ (This MUST be the full overpayment amount mentioned on the first page of this notice.)

_____ _____
Signature Date

☐ ALLOTMENT REDUCTION OPTION

PLEASE NOTE: If you do not pay the entire amount due within 30 days of this notice, this repayment option will start automatically, and your benefits will be reduced by 10% of your household's monthly allotment, which is $1 or $10.00 per month, whichever is greater.

You may choose to increase the amount of benefits we deduct from your monthly SNAP issuance above the amount mentioned above.

This repayment schedule may change without notice if your allotment changes. If repayment is made through allotment reduction and your SNAP case subsequently closes, you must contact the DHS Claims, Collections, and Recoveries Unit within ten days of your case closing to make arrangements for repayment of the remaining claim balance.

I agree to repay by this method using an allotment reduction amount above the standard amount mentioned above.

I agree to repay the over issuance amount of $_____ with this repayment option by agreeing to have $_____ deducted from my monthly SNAP issuance.

_____ _____
Signature Date

☐ ELECTRONIC BENEFIT TRANSFER (EBT) CARD PAYMENT OPTION

If you presently have SNAP benefits on your EBT card, you may elect to use all or a portion of these benefits to reduce this claim balance. If this payment does not pay this claim in full, you should also select option 1 or 2 above as a subsequent payment method.

$_____ is the amount of EBT SNAP benefits that I wish to pay against this claim.

I agree to repay the over issuance amount of $_____ with this repayment option.

_____ _____
Signature Date

Should your household's circumstances change, you have the right to request a renegotiation of this repayment agreement. DHS may reduce any part of the claim if the agency believes that the household is not able to repay the claim. You may make this request by contacting the DHS Claims, Collections, and Recoveries Unit at (401) 415-8400.

If you wish to obtain a lawyer, representatives from Rhode Island Legal Services, Inc. may be available to represent you, without charge. Their telephone number is (401) 274-2652 or 1-800-662-5034. Make checks or money orders payable to: Rhode Island Department of Human Services. Please include your claim number on your check/money order.

NON- DISCRIMINATION CLAUSE

You have a RIGHT to non-discriminatory treatment. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint [ascr.usda.gov] and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.
In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS), do not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS and DHS do not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 206 Elmwood Avenue, Providence, RI 02907 telephone number 415-8500 (for deaf/hearing impaired 1-800-745-6575 Voice; 1-800-745-5555 TTY, or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI, the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for civil rights compliance for all agency programs. The Secretary of EOHHS is responsible for Medicaid related discrimination issues and any such complaints will be referred accordingly.

STATE OF RHODE ISLAND
P.O. BOX 8709
CRANSTON, RI 02920-8787

APPEAL RIGHTS

You may have the right to appeal and have an Administrative Fair Hearing if you disagree with our decisions. You may:

1. **Call us to discuss the benefit decision.** Contact us at the telephone number at the top of the first page of this notice. Be sure to have this notice and the case/identification number on-hand when you call.
2. **Appeal for an Administrative Fair hearing.** An Appeal is a formal request asking for the decision to be reviewed at an administrative hearing. Please continue reading for further information.

What is a fair hearing?
A fair hearing is a chance for you to tell an administrative hearing officer why you disagree with the agency's decision about your eligibility, benefits, and/or any costs you must pay. An agency representative is also present at the hearing to explain the basis for the agency decision. By law, the administrative officer must review the facts of the case presented by both sides in a fair and objective manner.

Deadlines for appeals and asking for a fair hearing
The chart below explains the deadlines for filing an appeal for each program. For some programs, your benefits or services may be continued until a hearing decision is made if you appeal by the deadlines listed in the chart. If you miss this deadline, you may lose your right to appeal. After you have filed your appeal, we will schedule your hearing and issue a decision within 90 days, or 60 days if the hearing relates to your SNAP benefits. A decision will issue on all HealthSource RI appeals within 90 days of the date an appeal request is received, as administratively feasible.

Program	You must file an appeal in:	Will benefits continue if the appeal is made within 10 days of the notice ("Aid Pending")?
Medicaid	30 days after the notice date plus five days for mailing time	Yes, benefits will automatically continue unless you tell us otherwise
SNAP	90 days from the notice mail date	Yes, benefits will automatically continue unless you tell us otherwise
CCAP	30 days from the notice mail date	Benefits may be reduced until a hearing decision is made.
GPA	10 days from the notice mail date	Yes, but the request must be made in writing
Private Health Insurance	30 days after the notice date plus five days for mailing time.	You must call HealthSource RI within 30 days of the notice to request Aid-Pending.
All other programs	30 days from the notice mail date	Yes

Expedited Appeals
You have the right to an expedited appeal if you have an immediate need for health services or SNAP benefits and waiting for a standard appeal could seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function. We must decide expedited appeals as quickly as possible, given the circumstances. If we deny your request for an expedited appeal, we must inform you quickly, and we must handle your appeal through our standard process.

Right to Continue Benefits While Awaiting Hearing
You may have the right to have your benefits continue unchanged while you wait for your hearing (this is called "Aid-Pending"). Except for Private Health Insurance through HealthSource RI, if you appeal within 10 days, in most instances, you will be automatically granted Aid-Pending. Unless you can show otherwise, for Medicaid and HealthSource RI, we will assume that you received the notice 5 days after the date on the notice.

If you have Medicaid and you receive Aid-Pending, and then you lose your appeal, the State may make you pay back its costs for covering you during the Aid-Pending period. For HealthSource RI, Aid-Pending is only available if you are appealing an eligibility redetermination that occurred within 30 days of the date you file your appeal, and the request is made by telephone to HealthSource RI at 1-855-840-HSRI (4774). If you are receiving tax credits to help pay for your premiums and you receive Aid-Pending, and then you lose your appeal, then you may owe extra money in your federal taxes next year. If you pay monthly premiums, you must still pay during the Aid-Pending period.

If you receive SNAP, RIW or GPA benefits and receive Aid-Pending, and you lose your appeal, you may need to pay back the benefits you were issued but were not entitled to during this period.

Right to Represent Yourself and Right to be Represented
You have the right to represent yourself at the hearing, or to be represented by anyone you choose, including an attorney, advocate, friend, or relative.

Legal advice is available from Rhode Island Legal Services, Inc. at 274-2652 or 1-800-662-5034. If you choose to have Legal representation, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the Legal representative access to the Agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

Eligibility of Other Household Members May be Affected
Our appeal decision may result in changes to the eligibility of another member of your household.

Access to Your Case Record
You have the right to see your case record, including any evidence the State will use at your hearing. To view your case record, call us at 1-855-MYRIDHS (1-855-697-4347). If you are appealing an action taken by HealthSource RI, you may request a copy of your record by calling: 1-855-840-HSRI (4774).

Informal Resolution
We may be able to fix your problem quickly without a hearing. Please call 1-855-MYRIDHS (1-855-697-4347) so that we can review your case informally. If you are appealing an action taken by HealthSource RI, you may contact HealthSource RI at 1-855-840-HSRI (4774) to request an informal review of your appeal. We will reach out to you in an effort to resolve your appeal informally. Your right to a hearing will not be impacted by efforts to resolve your issue informally.

APPEAL FORM

Appeal Request Process

You may request an appeal by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- **Online.** Log into your account at www.healthyrhode.ri.gov and click on "file an appeal".
- **By phone.** You can file an appeal regarding Medicaid and Purchased Health Coverage through HealthSource RI by calling HealthSource RI at 1-855-840-HSRI (4774). For questions about filing an appeal for human services programs such as SNAP, RIW, Child Care, GPA, or SSP call the Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347).
- **In person.** For in-person assistance visit www.dhs.ri.gov to view office locations.
- **By mail**. Complete this form and mail it to: ATTN: Appeals State of Rhode Island, PO Box 8709 Cranston, RI 02920-8787.

Name (required):_____

Date of Birth (required):_____

Account Number: (as displayed at the top of the notice): _____

Address (required):_____

Phone number:_____

Email:_____

Do you need help speaking, reading or writing English? ☐ Yes ☐ No:

If yes, what is your primary language? _____

Preferred method of contact (circle one): email / paper mail

You must check off the reason(s) for your appeal:

Health Coverage:	Human Services:	
_____ Medicaid	_____ SNAP	_____ GPA
_____ Purchased plan through HSRI	_____ RIW	_____ CHILD CARE
_____ Both/Unsure	_____ SSP	

_____ Other (Please explain) _____

Please explain the reason for your appeal:

_____

_____

_____

_____

Do you need important health services or SNAP benefits immediately? If so, would you like an expedited appeal? ☐ Yes ☐ No:

If yes, please explain:

_____

_____

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR SNAP BENEFITS FOR WHICH I AM DETERMINED INELIGIBLE.

☐ Check this box if someone is going to help you with the appeal or represent you during the appeals process. This can be an attorney, friend, or family member. Provide this person's contact information:

Name: _____
Phone: _____
Address: _____
Email: _____

Would you like your coverage and benefits to continue unchanged while you wait for a hearing decision? ☐ Yes ☐ No:

Signature _____ Date _____
(Recipient)

TO BE COMPLETED BY THE AGENCY ONLY:

APPEAL IS ABOUT: _____ RIW _____ MEDICAID _____ GPA
_____ SNAP _____ PURCHASED HEALTH PLAN _____ CHILD CARE
_____ OTHER

Indicate Specific Policy Manual Reference: Section(s) _____

Agency response to appeal/explanation: _____

_____

_____

_____

Agency Representative (Signature) _____ Supervisor (Signature) _____
(Print Name) _____ (Print Name) _____

Local Office _____

ATTENTION: Language assistance services are available to you free of charge. Call . 1-855-697-4347 (TTY 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-697-4347 (TTY 711)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-697-4347 (TTY 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-697-4347 (TTY 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-697-4347 (TTY 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-855-697-4347 (TTY 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-697-4347 (ATS 711)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-697-4347 (TTY 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-697-4347 (TTY 711)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-855-697-4347 TTY 711

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-697-4347 (телетайп 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-697-4347 (TTY 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-697-4347 (TTY 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-697-4347 **(TTY 711)** 번으로 전화해 주십시오

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-697-4347 (TTY 711).

Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá 1-855-697-4347 (TTY 711)

Non-Discrimination Notice

The Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS) does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 206 Elmwood Avenue, Providence, RI 02907, telephone number (401) 415-8500 (for deaf/hearing impaired 1-800-745-6575 voice; TTY 711).

Para más información visite www.healthyrhode.ri.gov

Para mais informações visite www.healthyrhode.ri.gov

STATE OF RHODE ISLAND
P.O BOX 8709P.O BOX
8709
CRANSTON, RI 02920-8787

Date: 04/03/2020
Case Number: Mockup2 (change in expenses)

HOH's Name
<Address Line 1>
<Address Line 2>
<City, State Zip code>

How to Contact Us
Go Online: www.healthyrhode.ri.gov

For questions about affordable health coverage or human services programs, call Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347)

DEMAND LETTER FOR SNAP OVERISSUANCE

Dear <Head of Household's Name>,

For a detailed calculation of the overpayment amount, please see attached Overissuance Summary.

Please sign the enclosed repayment agreement and return it to this office within thirty (30) days or by 05/04/2020. If you fail to make an agreement and fail to make a payment, further appropriate action will be taken to recover the overpayment.

Should your household's circumstances change, you have the right to request a renegotiation of this repayment agreement. DHS may reduce any part of the claim if the agency believes that the household is not able to repay the claim. You may make this request by contacting the DHS Claims, Collections, and Recoveries Unit at (401) 415-8400.

If you wish to obtain a lawyer, representatives from Rhode Island Legal Services, Inc. may be available to represent you, without charge. Their telephone number is (401) 274-2652 or 1-800-662-5034. Make checks or money orders payable to: Rhode Island Department of Human Services. Please include your claim number on your check/money order.

OPTIONS FOR REPAYMENT

You must repay us for the over issued benefits you received. You may repay us by making a cash repayment agreement or Electronic Benefit Transfer (EBT) Card Payment. If you do not choose a repayment option and you are active on SNAP benefits, your monthly will be automatically reduced. Additional information about selecting your repayment method appears later on this notice.

You must make arrangements to repay us and return the agreement portion of this form by 05/04/2020 to the DHS Claims, Collections, and Recoveries Unit at 195 Buttonwoods Ave, Warwick, RI, 02886.

We intend to collect from all adults who were in the household when the over issuance occurred, whether they stay in the same household or move to a different household.

PENALTIES FOR NONPAYMENT

If you fail to make an agreement or you make an agreement and fail to make a payment, further appropriate action will be taken to recover the overpayment. If you are currently receiving SNAP benefits, your SNAP allotment may be reduced as early as the month following the date of this letter.

Failure to enter into a Voluntary Repayment Agreement or failure to pay after making an agreement will result in this claim being submitted to the Treasury Offset Program (TOP). TOP is a federal program for collection of debts that includes but is not limited to IRS Tax Refund Intercepts, Federal Salary Offsets, and Social Security Administration (SSA) recoupments. Fees may also be added to the debt for TOP offsets. TOP can be avoided by repaying the debt in full or agreeing to an acceptable repayment agreement on the following pages. If you have filed for bankruptcy, your claim will not be referred to TOP while there is an automatic stay in place.

Federal regulations allow the states to use various collection methods to collect this claim, including the use of private collection agencies, state tax refund and lottery offsets, wage garnishments, property liens and small claims court.

If a claim becomes delinquent, the household may be subject to additional processing charges. **A default of the repayment agreement will result in the entire debt becoming immediately due and payable.**

YOUR RIGHTS

You have a right to discuss this agency determination of overpayment, or the amount of overpayment further with DHS and to request an adjustment conference with the supervisor.

You also have a right to inspect and copy our records relating to this claim.

If you disagree with this determination, you have a right to a hearing. However, you must appeal this action within 90 days of the date of this notice, which is [redacted]. (See enclosed Appeal Form). If you have already received a Fair Hearing on this claim, you will not be able to appeal again. Please see your original hearing decision.

If you have any questions regarding this notice, call the Claims, Collections, and Recoveries Unit at (401) 415-8400.

OVERISSUANCE SUMMARY

[redacted]

[redacted]

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]		[redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted] [redacted]

STATE OF RHODE ISLAND
P.O BOX 8709P.O BOX
8709
CRANSTON, RI 02920-8787

Date: 04/03/2020
Case Number: Mockup2 (change in expenses)

HOH's Name
<Address Line 1>
<Address Line 2>
<City, State Zip code>

How to Contact Us
Go Online: www.healthyrhode.ri.gov

For questions about affordable health coverage or human services programs, call Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347)

REPAYMENT AGREEMENT

FOR HOUSEHOLDS NOT RECEIVING SNAP BENEFITS AT THIS TIME

If you are not receiving SNAP benefits at this time, you may repay the entire amount of the claim by check or money order, or funds from an EBT benefits account, all at once, or you may repay part of the claim now and then repay the rest in monthly installments. We will notify you if you fail to make payments. Please check the repayment method you wish to use and sign the agreement.

☐ CASH REPAYMENT OPTION

I agree to repay the over issuance amount in the following way: Please check the repayment method you wish to use and sign below.

____ Monthly payments of: $_____ (note: the minimum monthly payment must be at least $25)
The first payment is due by **0**

____ Pay in full all at once: Lump sum of $ _____ to be paid within 30 days or by **0**

Mail form and initial payment to:
DHS Claims, Collections, and Recoveries Unit
195 Buttonwoods Ave
Warwick, RI, 02886

Mail recurring cash payments to:
Financial Management
Louis Pasteur Bldg., 3rd floor
57 Howard Avenue
Cranston, RI 02920

I agree to repay the over issuance amount of $_____ with this repayment option.

_____ Signature

_____ Date

☐ ELECTRONIC BENEFIT TRANSFER (EBT) CARD PAYMENT OPTION

If you presently have SNAP benefits on your EBT card, you may elect to use all or a portion of these benefits to reduce this claim balance. If this payment does not pay this claim in full, you should also select option above as a subsequent payment method.

$_____ is the amount of EBT SNAP benefits that I wish to pay against this claim.

I agree to repay the over issuance amount of $_____ with this repayment option.

_____ _____

Signature Date

Should your household's circumstances change, you have the right to request a renegotiation of this repayment agreement. DHS may reduce any part of the claim if the agency believes that the household is not able to repay the claim. You may make this request by contacting the DHS Claims, Collections, and Recoveries Unit at (401) 415-8400.

If you wish to obtain a lawyer, representatives from Rhode Island Legal Services, Inc. may be available to represent you, without charge. Their telephone number is (401) 274-2652 or 1-800-662-5034. Make checks or money orders payable to: Rhode Island Department of Human Services. Please include your claim number on your check/money order.

NON- DISCRIMINATION CLAUSE

You have a RIGHT to non-discriminatory treatment. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint [ascr.usda.gov] and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. USDA is an equal opportunity provider, employer, and lender.
In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS), do not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS and DHS do not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 206 Elmwood Avenue, Providence, RI 02907 telephone number 415-8500 (for deaf/hearing impaired 1-800-745-6575 Voice; 1-800-745-5555 TTY, or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI, the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for civil rights compliance for all agency programs. The Secretary of EOHHS is responsible for Medicaid related discrimination issues and any such complaints will be referred accordingly.

STATE OF RHODE ISLAND
P.O. BOX 8709
CRANSTON, RI 02920-8787

APPEAL RIGHTS

You may have the right to appeal and have an Administrative Fair Hearing if you disagree with our decisions. You may:

1. **Call us to discuss the benefit decision.** Contact us at the telephone number at the top of the first page of this notice. Be sure to have this notice and the case/identification number on-hand when you call.
2. **Appeal for an Administrative Fair hearing.** An Appeal is a formal request asking for the decision to be reviewed at an administrative hearing. Please continue reading for further information.

What is a fair hearing?
A fair hearing is a chance for you to tell an administrative hearing officer why you disagree with the agency's decision about your eligibility, benefits, and/or any costs you must pay. An agency representative is also present at the hearing to explain the basis for the agency decision. By law, the administrative officer must review the facts of the case presented by both sides in a fair and objective manner.

Deadlines for appeals and asking for a fair hearing
The chart below explains the deadlines for filing an appeal for each program. For some programs, your benefits or services may be continued until a hearing decision is made if you appeal by the deadlines listed in the chart. If you miss this deadline, you may lose your right to appeal. After you have filed your appeal, we will schedule your hearing and issue a decision within 90 days, or 60 days if the hearing relates to your SNAP benefits. A decision will issue on all HealthSource RI appeals within 90 days of the date an appeal request is received, as administratively feasible.

Program	You must file an appeal in:	Will benefits continue if the appeal is made within 10 days of the notice ("Aid Pending")?
Medicaid	30 days after the notice date plus five days for mailing time	Yes, benefits will automatically continue unless you tell us otherwise
SNAP	90 days from the notice mail date	Yes, benefits will automatically continue unless you tell us otherwise
CCAP	30 days from the notice mail date	Benefits may be reduced until a hearing decision is made.
GPA	10 days from the notice mail date	Yes, but the request must be made in writing
Private Health Insurance	30 days after the notice date plus five days for mailing time.	You must call HealthSource RI within 30 days of the notice to request Aid-Pending.
All other programs	30 days from the notice mail date	Yes

Expedited Appeals
You have the right to an expedited appeal if you have an immediate need for health services or SNAP benefits and waiting for a standard appeal could seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function. We must decide expedited appeals as quickly as possible, given the circumstances. If we deny your request for an expedited appeal, we must inform you quickly, and we must handle your appeal through our standard process.

Right to Continue Benefits While Awaiting Hearing
You may have the right to have your benefits continue unchanged while you wait for your hearing (this is called "Aid-Pending"). Except for Private Health Insurance through HealthSource RI, if you appeal within 10 days, in most instances, you will be automatically granted Aid-Pending. Unless you can show otherwise, for Medicaid and HealthSource RI, we will assume that you received the notice 5 days after the date on the notice.

If you have Medicaid and you receive Aid-Pending, and then you lose your appeal, the State may make you pay back its costs for covering you during the Aid-Pending period. For HealthSource RI, Aid-Pending is only available if you are appealing an eligibility redetermination that occurred within 30 days of the date you file your appeal, and the request is made by telephone to HealthSource RI at 1-855-840-HSRI (4774). If you are receiving tax credits to help pay for your premiums and you receive Aid-Pending, and then you lose your appeal, then you may owe extra money in your federal taxes next year. If you pay monthly premiums, you must still pay during the Aid-Pending period.

If you receive SNAP, RIW or GPA benefits and receive Aid-Pending, and you lose your appeal, you may need to pay back the benefits you were issued but were not entitled to during this period.

Right to Represent Yourself and Right to be Represented
You have the right to represent yourself at the hearing, or to be represented by anyone you choose, including an attorney, advocate, friend, or relative.

Legal advice is available from Rhode Island Legal Services, Inc. at 274-2652 or 1-800-662-5034. If you choose to have Legal representation, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the Legal representative access to the Agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

Eligibility of Other Household Members May be Affected
Our appeal decision may result in changes to the eligibility of another member of your household.

Access to Your Case Record
You have the right to see your case record, including any evidence the State will use at your hearing. To view your case record, call us at 1-855-MYRIDHS (1-855-697-4347). If you are appealing an action taken by HealthSource RI, you may request a copy of your record by calling: 1-855-840-HSRI (4774).

Informal Resolution
We may be able to fix your problem quickly without a hearing. Please call 1-855-MYRIDHS (1-855-697-4347) so that we can review your case informally. If you are appealing an action taken by HealthSource RI, you may contact HealthSource RI at 1-855-840-HSRI (4774) to request an informal review of your appeal. We will reach out to you in an effort to resolve your appeal informally. Your right to a hearing will not be impacted by efforts to resolve your issue informally.

APPEAL FORM

Appeal Request Process

You may request an appeal by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- **Online.** Log into your account at www.healthyrhode.ri.gov and click on "file an appeal".
- **By phone.** You can file an appeal regarding Medicaid and Purchased Health Coverage through HealthSource RI by calling HealthSource RI at 1-855-840-HSRI (4774). For questions about filing an appeal for human services programs such as SNAP, RIW, Child Care, GPA, or SSP call the Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347).
- **In person.** For in-person assistance visit www.dhs.ri.gov to view office locations.
- **By mail**. Complete this form and mail it to: ATTN: Appeals State of Rhode Island, PO Box 8709 Cranston, RI 02920-8787.

Name (required):_____

Date of Birth (required):_____

Account Number: (as displayed at the top of the notice): _____

Address (required):_____

Phone number:_____

Email:_____

Do you need help speaking, reading or writing English? ☐ Yes ☐ No:

If yes, what is your primary language? _____

Preferred method of contact (circle one): email / paper mail

You must check off the reason(s) for your appeal:

Health Coverage:	Human Services:	
_____ Medicaid	_____ SNAP	_____ GPA
_____ Purchased plan through HSRI	_____ RIW	_____ CHILD CARE
_____ Both/Unsure	_____ SSP	

_____ Other (Please explain) _____

Please explain the reason for your appeal:

_____

_____

_____

_____

Do you need important health services or SNAP benefits immediately? If so, would you like an expedited appeal? ☐ Yes ☐ No:

If yes, please explain:

_____

_____

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR SNAP BENEFITS FOR WHICH I AM DETERMINED INELIGIBLE.

☐ Check this box if someone is going to help you with the appeal or represent you during the appeals process. This can be an attorney, friend, or family member. Provide this person's contact information:

Name: _____
Phone: _____
Address: _____
Email: _____

Would you like your coverage and benefits to continue unchanged while you wait for a hearing decision? ☐ Yes ☐ No:

Signature _____ Date _____
(Recipient)

TO BE COMPLETED BY THE AGENCY ONLY:

APPEAL IS ABOUT: _____ RIW _____ MEDICAID _____ GPA
_____ SNAP _____ PURCHASED HEALTH PLAN _____ CHILD CARE
_____ OTHER

Indicate Specific Policy Manual Reference: Section(s) _____

Agency response to appeal/explanation: _____

_____

_____

_____

Agency Representative (Signature) _____ Supervisor (Signature) _____
(Print Name) _____ (Print Name) _____
Local Office _____

ATTENTION: Language assistance services are available to you free of charge. Call . 1-855-697-4347 (TTY 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-697-4347 (TTY 711)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-697-4347 (TTY 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-697-4347 (TTY 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-697-4347 (TTY 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-855-697-4347 (TTY 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-697-4347 (ATS 711)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-697-4347 (TTY 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-697-4347 (TTY 711)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-855-697-4347 TTY 711

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-697-4347 (телетайп 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-697-4347 (TTY 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-697-4347 (TTY 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-697-4347 **(TTY 711)** 번으로 전화해 주십시오

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-697-4347 (TTY 711).

Dè dɛ nìà kɛ dyédé gbo: Ɔ jŭ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jŭ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá 1-855-697-4347 (TTY 711)

Non-Discrimination Notice

The Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS) does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 206 Elmwood Avenue, Providence, RI 02907, telephone number (401) 415-8500 (for deaf/hearing impaired 1-800-745-6575 voice; TTY 711).

For More information visit www.healthyrhode.ri.gov

Para más información visite www.healthyrhode.ri.gov

Para mais informações visite www.healthyrhode.ri.gov

[redacted]

Date: 04/03/2020
Case Number: Mockup1 (change in HH size)

[redacted]

[redacted]

[redacted]

DEMAND LETTER FOR SNAP OVERISSUANCE

Dear <Head of Household's Name>,

It has been determined that you or your household received $815.00 more SNAP benefits than you were eligible to receive during the period of 01/01/2015 to 05/31/2015 due to the following reason:

Reason: IHE24 – You did not report change in household composition

For a detailed calculation of the overpayment amount, please see attached overissuance worksheet.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

OVERISSUANCE SUMMARY

Overissuace Reason:
IHE24 – You did not report change in household composition

Overissuance Reason Details:
You did not timely report to DHS that John Doe left your household in December 2013.

The following calculations explain how the amount of your over issuance(s) was determined:

Date Benefits Received	Original HH Size	Benefits Received	Correct HH Size	Change in Income	Change in Expenses/ Deductions	Correct Benefit Amount	Credit for Unused EBT	Overissuance
01/2015	2	$357	1			$194		$163
02/2015	2	$357	1			$194		$163
03/2015	2	$357	1			$194		$163
04/2015	2	$357	1			$194		$163
05/2015	2	$357	1			$194		$163

Total Overissuance: **$815.00**

Claim Number: **123451**

Liable Individuals: Jane Doe
John Doe

[redacted]

Date: 04/03/2020
Case Number: Mockup2 (change in expenses)

[redacted]

[redacted]

DEMAND LETTER FOR SNAP OVERISSUANCE

Dear <Head of Household's Name>,

It has been determined that you or your household received $935.00 more SNAP benefits than you were eligible to receive during the period of 01/01/2015 to 05/31/2015 due to the following reason:

Reason: IHE26 – You did not report change in shelter expenses/rent/mortgage

For a detailed calculation of the overpayment amount, please see attached Overissuance Summary.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

OVERISSUANCE SUMMARY

Overissuace Reason:
IHE26 – You did not report a change in shelter expenses/rent/mortgage

Overissuance Reason Details:

The following calculations explain how the amount of your over issuance(s) was determined:

Date Benefits Received	Original HH Size	Benefits Received	Correct HH Size	Change in Income	Change in Expenses/ Deductions	Correct Benefit Amount	Credit for Unused EBT	Overissuance
01/2015	2	$357	2		-$845	$170		$187
02/2015	2	$357	2		-$845	$170		$187
03/2015	2	$357	2		-$845	$170		$187
04/2015	2	$357	2		-$845	$170		$187
05/2015	2	$357	2		-$845	$170		$187

Total Overissuance: **$935.00**

Claim Number: **123456**

Liable Individuals: Jane Doe
John Doe

[redacted]

Date: 04/03/2020
Case Number: Mockup3 (multiple reasons)

[redacted]

[redacted]

DEMAND LETTER FOR SNAP OVERISSUANCE

Dear <Head of Household's Name>,

It has been determined that you or your household received $983.00 more SNAP benefits than you were eligible to receive during the period of 01/01/2015 to 05/31/2015 due to the following reason:

Reason: AE31 – DHS did not act on your change in Able-bodied Adult Without Dependents (ABAWD) status
AE20 – DHS did not include sponsor income or increase in sponsor income

For a detailed calculation of the overpayment amount, please see attached Overissuance Summary.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

OVERISSUANCE SUMMARY

Overissuace Reason:
AE31 – DHS did not act on your change in Able-bodied Adult Without Dependents (ABAWD) status
AE20 – DHS did not include sponsor income or increase in sponsor income

Overissuance Reason Details:
John Doe was not eligible for SNAP benefits as of 03/2015 because he used up his 3 ABAWD months. DHS did not count Sponsor Bob Sample's increased income reported in 12/2014. The increase stopped in 04/2015.

The following calculations explain how the amount of your over issuance(s) was determined:

Date Benefits Received	Original HH Size	Benefits Received	Correct HH Size	Change in Income	Change in Expenses/ Deductions	Correct Benefit Amount	Credit for Unused EBT	Overissuance
01/2015	2	$357	2	$300		$172		$185
02/2015	2	$357	2	$300		$172		$185
03/2015	2	$357	1	$300		$132		$225
04/2015	2	$357	1	$300		$132		$225
05/2015	2	$357	1			$194		$163

Total Overissuance: **$983.00**

Claim Number: **123452**

Liable Individuals: Jane Doe
John Doe

[redacted]

Date: 04/03/2020
Case Number: Mockup4 (multiple changes same column)

[redacted]

[redacted]

DEMAND LETTER FOR SNAP OVERISSUANCE

Dear <Head of Household's Name>,

It has been determined that you or your household received $1527.00 more SNAP benefits than you were eligible to receive during the period of 01/01/2015 to 05/31/2015 due to the following reason:

Reason: IHE1 – You did not report income or increase in income received from wages and/or salaries
IHE13 – You did not report child support/alimony or increase in those payments received
IHE33 – You did not report decrease in dependent care expenses
IHE34 – You did not report decrease in medical expenses

For a detailed calculation of the overpayment amount, please see attached Overissuance Summary.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

OVERISSUANCE SUMMARY

Overissuace Reason:
IHE1 – You did not report income or increase in income received from wages and/or salaries
IHE13 – You did not report child support/alimony or increase in those payments received
IHE33 – You did not report decrease in dependent care expenses
IHE34 – You did not report decrease in medical expenses

Overissuance Reason Details:
You did not timely report to DHS that John Doe started a new job in January 2015 making $200 a week. You also did not report an increase of $150 in weekly child support received for minor Katie Doe which started in March 2015 and a decrease of $100 a week in day care expenses for her that started in April 2015. You did not report the $150 a month decrease in home health care services for Nana Doe that started in January 2015.

The following calculations explain how the amount of your over issuance(s) was determined:

Date Benefits Received	Original HH Size	Benefits Received	Correct HH Size	Change in Income	Change in Expenses/ Deductions	Correct Benefit Amount	Credit for Unused EBT	Overissuance
01/2015	4	$649	4	$866	-$150	$424		$225
02/2015	4	$649	4	$866	-$150	$424		$225
03/2015	4	$649	4	$1516	-$150	$370		$279
04/2015	4	$649	4	$1516	-$583	$250		$399
05/2015	4	$649	4	$1516	-$583	$250		$399

Total Overissuance: **$1527.00**

Claim Number: **123454**

Liable Individuals: Jane Doe
John Doe

EXHIBIT C

Code	Description
IHE1	YOU DID NOT REPORT INCOME OR INCREASE IN INCOME RECEIVED FROM WAGES AND/OR SALARIES
IHE2	YOU DID NOT REPORT INCOME OR INCREASE IN INCOME RECEIVED FROM SELF-EMPLOYMENT
IHE3	YOU DID NOT REPORT INCOME OR INCREASE IN INCOME RECEIVED FROM RENTAL PROPERTY
IHE4	YOU DID NOT REPORT INCOME OR INCREASE IN INCOME RECEIVED FROM TRAINING PROGRAM
IHE5	YOU DID NOT REPORT INCOME OR INCREASE IN INCOME RECEIVED FROM WORK STUDY/FELLOWSHIP
IHE6	YOU DID NOT REPORT BENEFITS RECEIVED FROM RI WORKS (RIW) OR INCREASE IN RIW
IHE7	YOU DID NOT REPORT INCOME RECEIVED FROM GENERAL PUBLIC ASSISTANCE (GPA) OR INCREASE IN GPA
IHE8	YOU DID NOT REPORT RECEIPT OF OR INCREASE IN SUPPLEMENTAL SECURITY INCOME (SSI) OR SOCIAL SECURITY DISABILITY INCOME (SSDI)
IHE9	YOU DID NOT REPORT UNEMPLOYMENT (UI) BENEFITS OR INCREASE IN UI RECEIVED
IHE10	YOU DID NOT REPORT WORKERS' COMPENSATION (WC) OR INCREASE IN WC RECEIVED
IHE11	YOU DID NOT REPORT PENSION / RETIREMENT BENEFITS OR INCREASE IN THOSE BENEFITS RECEIVED
IHE12	YOU DID NOT REPORT FOSTER CARE PAYMENTS OR INCREASE IN THOSE PAYMENTS RECEIVED
IHE13	YOU DID NOT REPORT CHILD SUPPORT/ALIMONY OR INCREASE IN THOSE PAYMENTS RECEIVED
IHE14	YOU DID NOT REPORT VETERANS' (VA) BENEFITS OR INCREASE IN VA BENEFITS RECEIVED
IHE15	YOU DID NOT REPORT INCOME RECEIVED FROM STOCKS/BONDS
IHE16	YOU DID NOT REPORT INCOME FROM SCHOLARSHIPS, LOANS OR GRANTS
IHE17	YOU DID NOT REPORT CASH CONTRIBUTIONS RECEIVED
IHE18	YOU DID NOT REPORT INTEREST INCOME/DIVIDENDS/ROYALTIES RECEIVED
IHE19	YOU DID NOT REPORT AN INSURANCE SETTLEMENT/LUMP SUM RECEIVED
IHE20	YOU DID NOT REPORT SPONSOR INCOME OR INCREASE IN SPONSOR INCOME
IHE21	YOU DID NOT REPORT INCOME FROM A ROOMER / BOARDER
IHE22	YOU DID NOT REPORT ALL ASSETS / RESOURCES
IHE23	YOU DID NOT REPORT CHANGE IN ABLE-BODIED ADULT WITHOUT DEPENDENTS (ABAWD) STATUS
IHE24	YOU DID NOT REPORT CHANGE IN HOUSEHOLD COMPOSITION
IHE25	YOU DID NOT REPORT A CHANGE IN STATUS OF A MEMBER

IHE26	YOU DID NOT REPORT CHANGE IN SHELTER EXPENSES/RENT/MORTGAGE
IHE27	YOU DID NOT REPORT YOU MOVED OUT OF STATE
IHE28	YOU RECEIVED DUPLICATE BENEFITS FROM RI OR OTHER STATE
IHE29	YOU DID NOT REPORT A CHANGE IN A TIMELY MANNER
IHE30	HOUSEHOLD RECEIVED BENEFITS PENDING A HEARING THAT WAS LOST
IHE31	HOUSEHOLD RECEIVED REPLACEMENT BENEFITS FOR WHICH NOT ELIGIBLE
IHE32	YOU DID NOT REPORT RECEIPT OF OR INCREASE IN TDI/TCI (TEMPORARY DISABILITY INSURANCE/TEMPORARY CAREGIVER INSURANCE)
IHE33	YOU DID NOT REPORT DECREASE IN DEPENDENT CARE EXPENSES
IHE34	YOU DID NOT REPORT DECREASE IN MEDICAL EXPENSES
IHE35	YOU DID NOT REPORT DECREASE IN CHILD SUPPORT PAYMENTS BEING MADE
IHE36	YOU DID NOT REPORT INSTITUTIONALIZATION/INCARCERATION OF 30 DAYS OR MORE
IPV1	YOU SOLD OR ATTEMPTED TO SELL FOOD STAMPS
IPV2	YOU MISUSED / TRIED TO MISUSE YOUR FOOD STAMP BENEFIT / EBT CARD
IPV3	YOU COMMITTED AN INTENTIONAL PROGRAM VIOLATION
AE1	DHS DID NOT INCLUDE INCOME OR INCREASE IN INCOME RECEIVED FROM WAGES AND/OR SALARIES
AE2	DHS DID NOT INCLUDE INCOME OR INCREASE IN INCOME RECEIVED FROM SELF-EMPLOYMENT
AE3	DHS DID NOT INCLUDE INCOME OR INCREASE IN INCOME RECEIVED FROM RENTAL PROPERTY
AE4	DHS DID NOT INCLUDE INCOME OR INCREASE IN INCOME RECEIVED FROM TRAINING PROGRAM
AE5	DHS DID NOT INCLUDE INCOME OR INCREASE IN INCOME RECEIVED FROM WORK STUDY/FELLOWSHIP
AE6	DHS DID NOT INLCUDE RI WORKS (RIW) BENEFITS OR INCREASE IN RIW RECEIVED
AE7	DHS DID NOT INCLUDE GENERAL PUBLIC ASSISTANCE (GPA) OR INCREASE IN GPA RECEIVED
AE8	DHS DID NOT INCLUDE SUPPLEMENTAL SECURITY INCOME (SSI) OR SOCIAL SECURITY DISABILITY INCOME (SSDI) OR INCREASE IN SSI/SSDI RECEIVED
AE9	DHS DID NOT INCLUDE UNEMPLOYMENT (UI) BENEFITS OR INCREASE IN UI RECEIVED
AE10	DHS DID NOT INCLUDE WORKERS' COMPENSATION (WC) OR INCREASE IN WC RECEIVED
AE11	DHS DID NOT INCLUDE PENSION / RETIREMENT BENEFITS OR INCREASE IN THOSE BENEFITS RECEIVED

AE12	DHS DID NOT INCLUDE FOSTER CARE PAYMENTS OR INCREASE IN THOSE PAYMENTS RECEIVED
AE13	DHS DID NOT INCLUDE CHILD SUPPORT/ALIMONY OR INCREASE IN THOSE PAYMENTS RECEIVED
AE14	DHS DID NOT INCLUDE VETERANS' (VA) BENEFITS OR INCREASE IN VA BENEFITS RECEIVED
AE15	DHS DID NOT INCLUDE INCOME RECEIVED FROM STOCKS/BONDS
AE16	DHS DID NOT INCLUDE INCOME FROM SCHOLARSHIPS, LOANS OR GRANTS
AE17	DHS DID NOT INCLUDE CASH CONTRIBUTIONS RECEIVED
AE18	DHS DID NOT INCLUDE INTEREST INCOME/DIVIDENDS/ROYALTIES RECEIVED
AE19	DHS DID NOT INCLUDE AN INSURANCE SETTLEMENT/LUMP SUM RECEIVED
AE20	DHS DID NOT INCLUDE SPONSOR INCOME OR INCREASE IN SPONSOR INCOME
AE21	DHS DID NOT INCLUDE INCOME FROM A ROOMER / BOARDER
AE22	DHS DID NOT INCLUDE ALL ASSETS / RESOURCES
AE23	DHS DID NOT ACT ON CHANGE IN HOUSEHOLD COMPOSITION
AE24	DHS DID NOT ACT ON CHANGE IN STATUS OF A MEMBER
AE25	DHS DID NOT ACT ON CHANGE IN SHELTER EXPENSES/RENT/MORTGAGE
AE26	DHS DID NOT ACT ON CHANGE IN STATE OF RESIDENCE
AE27	DHS DID NOT ACT ON CHANGE IN A TIMELY MANNER
AE28	DHS ISSUED SUPPLEMENTAL OR MANUAL BENEFITS IN ERROR
AE29	DHS DID NOT INCLUDE APPROPRIATE SHELTER/RENT/UTILITY EXPENSES
AE30	REPORTED INFORMATION WAS DISREGARDED OR NOT APPLIED
AE31	DHS DID NOT ACT ON YOUR CHANGE IN ABLE-BODIED ADULT WITHOUT DEPENDENTS (ABAWD) STATUS
AE32	DHS DID NOT INCLUDE TEMPORARY DISABILITY INSUANCE (TDI) OR TEMPORARY CAREGIVER INSUANCE (TCI) OR INCREASE IN THOSE BENEFITS RECEIVED
AE33	DHS DID NOT ACT ON DECREASE IN DEPENDENT CARE EXPENSES
AE34	DHS DID NOT ACT ON DECREASE IN REPORTED MEDICAL EXPENSES
AE35	DHS DID NOT ACT ON DECREASE IN CHILD SUPPORT PAYMENTS BEING MADE
AE36	DHS DID NOT ACT ON REMOVING HOUSEHOLD MEMBER INSTITUTIONALIZED OR INCARCERATED FOR MORE THE 30 DAYS
100	OTHER